



New Mexico Health Policy Commission Strategic Plan FY 2009-2012

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1. EXECUTIVE SUMMARY

The New Mexico Health Policy Commission (HPC) is a state agency that provides independent research, guidance and recommendations on health policy issues that impact the health status of New Mexicans. The HPC's vision is to assist New Mexicans by being the State's trusted advisor on health policy issues. The Commission will:

- Be valued by the executive branch, the legislative branch, peers, colleagues, and consumers for its independence and expertise;
- Provide leadership in identifying and researching critical health, health care delivery, and health care financing issues;
- Provide policy research and recommendations to the legislative and executive branches of state government;
- Maintain a work environment that encourages individual growth and teamwork.

This vision will be accomplished by:

- focusing on activities that will have the greatest impact on developing policy for New Mexicans' health care coverage;
- utilizing resources as effectively as possible;
- securing additional funding levels to support agency activities; and
- recruiting and retaining the best possible staff.

Key priorities for the next few years include:

- Contribute to, adopt, and advance best practices;
- Improve collaboration with other organizations and agencies;
- Build staff capabilities;
- Offer analysis and research services for legislative and executive requests;
- Continue to enhance the HIDD database to serve as a source of planning for healthcare for all New Mexicans;

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- Utilize the HIDD database to provide state health care trends for disease management and financing;
- Determine feasibility of securing grant funds;
- Implement the IT Strategic plan;
- Develop realistic performance measures;
- Improve the development and distribution of Quick Facts;
- Reevaluate the utility of the County Indigent Fund report;
- Produce a “white paper” that provides recommended options for improving health programs;
- Conduct an analysis of the economic impact of health care for undocumented immigrants;
- Enhance the reporting of County Indigent and Sole Community Provider Funds utilized in the state;
- Offer GIS and mapping services for state agencies with health related research;
- Review all related statutes and plan for additional research as allowed by statute and rules;
- Continue research on Access to Health Care;
- Update research on Health Care Workforce in New Mexico; and
- Collaborate with the Department of Insurance to construct a system that can address issues of Obstetrical Medical Malpractice Coverage.

2. BACKGROUND AND CONTEXT

2.1. Statutory authority.

The Health Policy Commission (HPC) was established by statute in 1991 to provide a forum for the discussion of complex and controversial health policy issues. The Commission (HPC) is an independent state agency, administratively attached to the Department of Finance and Administration. The HPC is responsible for providing technical assistance and formulating recommendations for both the Executive and Legislative branches of state government based on an objective analysis of data and information, public and professional input, and staff research.

The Commission consists of members appointed by the Governor and confirmed by the Senate to reflect the ethnic, economic, geographic and professional diversity of the state. Members serve for a three-year term. A list of the current Commissioners follows:

| | |
|---------------------------|---------------------------------|
| Frank Hesse, MD, Chairman | Seferino Montano, Vice Chairman |
| Dawn Brooks, MSN,MHC | Karen Kotch, PA |
| Eric Kraska, MD | Kim Maxwell |
| Moises Morales | Miles Nelson, MD |
| Alicia Roman | |

2.2. National and state context.

Health policy issues in the United States are currently receiving an increasing amount of attention. As our nation attempts to find ways to provide coverage to the growing ranks of the uninsured it is simultaneously faced with significant shortages of health professionals and an industry that continues to consume an increasing percentage of our nation's economic resources. Some have postulated that these factors and others may combine to create a "perfect storm" that could jeopardize our health care delivery system as we know it.

The state of NM has an executive who has committed himself to providing health coverage for all New Mexicans. Discussions led to studies leading to planning and expected implementation of a statewide health care plan. The HPC's role in

research will assist the state in accomplishing this plan and will assist with ongoing analysis and possible oversight.

In establishing the HPC, the New Mexico legislature determined that good health is high on the list of priorities. Achieving optimal health requires both individual and collective responsibility and action. Therefore, state government must assume a leadership role by establishing and implementing policies in all aspects of health. In order to fulfill its proper leadership obligation within public resource constraints, the state must perform a variety of carefully tailored roles in concert with individuals, the private sector and local, federal and tribal governments. Health care continues to require a growing portion of the state's public and private resources and impacts a broad segment of the state's economy. Therefore, it is necessary to maintain an entity for research, guidance and recommendations on health policy and planning issues.

2.3. The planning process.

The HPC has a long standing commitment to strategic planning and has undertaken a series of initiatives over the past several years. The most recent of these occurred in 2002, 2006, and 2008 and resulted in the current plan for the years 2009 – 2012. A number of changes have occurred at the state level and at the HPC. Due to these changes, it was appropriate for the HPC to revise their strategic plan.

The Commission identified two primary goals for the planning process:

- To develop a strategic plan that enhances the organizations impact on health policy issues, efficiently utilizes resources, and positions the agency for future environmental conditions;
- To engage in a process that maximizes the sharing of ideas, skills, and experience, develops consensus regarding resource use, and assures plan acceptance.

To accomplish these goals, a Strategic Planning Committee was organized and included staff members with a variety of perspectives. A list of committee members follows:

Liz Stefanics, PhD – Executive Director

Kristine "Kooch" Jacobus, MA – Deputy Director

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Carlos Beserra – Special Assistant for Projects

TC Shaffer, MA – Program Manager

Terry Reusser – IT Manager

Peggy Schummers – CFO/HR Manager

Elisha Leyba-Tercero, MS - Economist

Frank Hesse, MD – Chair

Seferino Montano – Vice Chair

Dawn Brooks, RN, MSN, MBA

Karen Kotch, PA

Eric Kraska, MD

Kim Maxwell

Moises Morales

Miles Nelson, MD

Alicia Roman

The 2005 strategic planning process was in three sessions and included working sessions for the committee as well as briefing sessions with the Commissioners. The same process was utilized in 2008.

Using this process, the following tasks were identified:

- Conduct a strategic assessment, including discussion of the current environment in which the HPC operates and how that might change in the next few years,
- Identify the Commissions current capabilities, and future opportunities;
- Develop the strategic direction, focusing on the Commission's mission, vision, and strategies; and
- Prepare management action plans, identifying key initiatives required to achieve the Commissions vision, established priorities and expected outcomes.

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A concerted effort was made to gather input from a wide variety of stakeholders. To this end, the 2005 consultant conducted personal interviews with the HPC staff members, most of the HPC commissioners and a number of individuals representing organizations and agencies having an interest in health policy issues (see appendix for a complete listing). This interview process was summarized and utilized as a basis for identifying critical issues and potential strategic initiatives.

The findings of the committee and the results of this process are described in subsequent sections of this document.

3. STRATEGIC ASSESSMENT

3.1. Approach.

The Committee developed a multi faceted approach to better understand the HPC's current strengths and weaknesses as well as potential future opportunities and threats. (SWOT)

3.2. Stakeholders.

Several organizations and agencies that are deeply involved with issues related to health policy in New Mexico were identified by the committee. Representatives of each were then contacted and personally interviewed by telephone between January and April, 2006. The following organizations participated:

- Molina Healthcare
- UNM – Center for Community Partnerships
- UNM – Institute for Public Health
- AARP
- New Mexico Trial Lawyers Association
- New Mexico Primary Care Association
- New Mexico Aging and Long Term Services Department
- New Mexico Department of Labor
- New Mexico Children Youth and Families Department
- New Mexico Department of Finance and Administration
- Office of the Governor of New Mexico
- New Mexico Developmental Disability Planning Council
- New Mexico Legislative Council Service
- New Mexico Hospital & Health Systems Association

Each organization provided background information regarding their interest in health policy issues and provided suggestions as to what the Health Policy Commission can do to enhance its performance.

These same agencies in 2008 were integrally involved in the discussion.

3.3. Strategic context.

The Planning team recognized a number of external influences that will help shape the future work of the HPC. These include the following:

- **Technology**

Continuing advances in hardware and software will challenge the Commission to maintain “state of the art” operation. Initiatives aimed at IT consolidation within state government will make it essential for HPC to establish strong relationships with OCIO.

- **Political**

It is critically important that the HPC stay attuned to the interests and priorities of New Mexico’s elected leaders. It is important to recognize that there are a number of other interests that will compete with HPC for funding and support.

- **Regulatory**

The legislation that established the HPC includes a number of statutory limitations that clearly influence what the agency can and cannot do. Amendments to current statutes and revisions of rules and regulations are necessary.

- **Administrative**

Although the HPC is a relatively small agency in terms of staff and budget, it is subject to the same administrative regulations and processes as all other State agencies.

- **Consumerism**

The growing influence of consumerism in health care and related information needs will also present a variety of challenges for the HPC.

- **Resources**

Significant budget cuts to the HPC as well as loss of FTE over the past five years have impacted the ability of the agency to produce the quantity and quality of research that the state of NM needs.

3.4. Strengths and weaknesses.

The Commission started its strategic planning effort recognizing the strengths that it can build upon in the future as well as weaknesses that need to be addressed. The key strengths identified include a professional, committed staff that works well as a team in an environment where there is staff autonomy, a high degree of trust and positive regard for management. The HPC has recently completed an IT upgrade and has access to a powerful base of data and information. This enables the staff to do a better job of gathering, researching and analyzing data. The agency is effective at bringing stakeholders together and facilitating dialogue from a neutral perspective. Finally, as a small organization, the agency is nimble and able to respond quickly to new requests.

The HPC planning team identified a number of weaknesses that must be addressed in order to facilitate continued growth and development. Foremost among these weaknesses is a lack of visibility and clear understanding of the agency's mission and priorities. The HPC website was redesigned and current and past research was posted for the general public to avail themselves.

Additionally, there is a perceived imbalance between the HPC's responsibilities and the resources available to support these. Continuing staff and budget reductions over the last number of years have resulted in excessive staffing changes. An increased focus on training and education are necessary due to these staff changes. This situation will be exacerbated in the next few years due to the expected retirement of a few long term employees. Finally, the Commission is considered by many as an agency that reacts to issues identified by other organizations, rather than providing leadership in identifying important health policy issues.

4. STRATEGIC DIRECTION

4.1. Approach.

The strategic planning effort focused the Commission's future direction, and strategic priorities. As a starting point, the Strategic Planning Committee revised the Commission's mission statement to give the stakeholders a clear understanding of the organization's purpose. The mission statement is designed to inspire organizational success and articulate a sense of purpose.

The next step was to devise a vision statement that captures HPC's future aspirations, provides direction, aligns key players and energizes stakeholders to pursue common goals.

4.2. Mission statement.

The Health Policy Commission (HPC) is a state agency that provides independent research, guidance and recommendations on health policy issues that impact the health status of New Mexicans.

4.3. Vision statement.

The Health Policy Commission (HPC) will assist New Mexicans by being the State's trusted advisor on health policy issues. The Commission will:

- Be valued by peers, colleagues and consumers for its independence and expertise;
- Provide leadership in identifying and researching critical health and health care delivery issues;
- Provide policy research and recommendations to the legislative and executive branches of state government;
- Maintain a work environment that encourages individual growth and teamwork.

5. STRATEGIC PRIORITIES

5.1. Current focus.

HPC's current focus is reflected in the goals articulated in its last strategic plan. These include the following;

- **Goal I:** Monitor the implementation of State Health Policy through research, analysis and development of policy recommendations
- **Goal II:** Create, sponsor and participate in partnerships, open forums and taskforce activities to develop strategies that facilitate the implementation of state health policy.
- **Goal III:** Enhance available information for planning, policymaking and consumers to make informed healthcare decisions and facilitate an efficient, effective healthcare system through the application of information technology.
- **Goal IV:** Promote awareness of HPC's leadership and objective forums for discussion of complex and controversial health policy and planning issues.

5.2. Future strategies.

Utilizing the balanced scorecard concept, the strategic planning committee agreed on the following future Goals in order to reshape and focus its future activities:

- **Goal 1:** Focus on activities that will have the greatest impact on New Mexicans' health status.
- **Goal 2:** Utilize resources as effectively as possible.
- **Goal 3:** Secure additional funding levels to support agency activities.
- **Goal 4:** Recruit and retain the best possible staff.

5.3. Priority tactics.

A number of specific tactics were identified and prioritized to support the above four key strategies. These were then prioritized taking into account input from the Commissioners so that the planning team could focus on an implementation action plan. The agreed upon tactics and priorities included:

- Contribute to, adopt, and advance best practices;
- Improve collaboration with other organizations and agencies;
- Build staff capabilities;
- Offer analysis and research services for legislative and executive requests;
- Continue to enhance the HIDD database to serve as a source of planning for healthcare for all New Mexicans;
- Utilize the HIDD database to provide state health care trends for disease management and financing;
- Determine feasibility of securing grant funds;
- Implement the IT Strategic plan;
- Develop realistic performance measures;
- Improve the development and distribution of Quick Facts;
- Reevaluate the utility of the County Indigent Fund report;
- Produce a “white paper” that provides recommended options for improving health programs;
- Conduct an analysis of the economic impact of health care for undocumented immigrants;
- Enhance the reporting of County Indigent and Sole Community Provider Funds utilized in the state;
- Offer GIS and mapping services for state agencies with health related research;
- Review all related statutes and plan for additional research as allowed by statute and rules;
- Continue research on Access to Health Care;
- Update research on Health Care Workforce in New Mexico; and
- Collaborate with the Department of Insurance to construct a system that can address issues of Obstetrical Medical Malpractice Coverage.

5.4. Ongoing Support.

Successful implementation of this plan will require a continuing commitment to the strategic planning process that includes periodic monitoring of implementation

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progress, establishment of annual measures of success, and the evaluation of priority tactics.

6. APPENDIX

Selected state laws and regulations

Stakeholders list

Health Policy Commission Act

9-7-11.1. Findings and purpose.

A. The legislature finds that good health is among our most cherished desires. To achieve optimal health requires both individual and collective responsibility and action, therefore, state government must assume a leadership role by establishing and implementing policies in all aspects of health. In order to fulfill its proper leadership obligation within public resource constraints, the state must perform a variety of carefully tailored roles in concert with individuals, the private sector and local, federal and tribal governments.

B. The Legislature also finds that health care requires a growing portion of the state's public and private resources and impacts a broad segment of the state's economy; a need, therefore, exists to establish an entity for research, guidance and recommendations on health policy and planning issues.

C. The purpose of the New Mexico health policy commission is to provide a forum for the discussion of complex and controversial health policy and planning issues and for the creative exploration of ideas, issues and problems surrounding health policy and planning, including the interrelations with education, the environment and economic well-being.

D. It is the policy of the state of New Mexico to promote optimal health; to prevent disease, disability and premature death; to improve the quality of life; and to assure that basic health services are available, accessible, acceptable and culturally appropriate, regardless of financial status. This policy shall be realized through the following organized efforts:

1. education, motivation and support of the individual in healthy behavior;
2. protection and improvement of the physical and social environments;
3. promotion of health services for early diagnosis and prevention of disease and disability; and
4. provisions of basic treatment services needed by all New Mexicans.

History: Laws 1991, ch. 139 P 1.

9-7-11.2. New Mexico health policy commission created; composition; duties.

A. There is created the "New Mexico health policy commission", which is administratively attached to the department of finance and administration.

B. The New Mexico health policy commission shall consist of eight members appointed by the governor with the advice and consent of the senate to reflect the ethnic, economic, geographic and professional diversity of the state. No member of the commission shall have a pecuniary or fiduciary interest in the health services industry for three years preceding his appointment to the commission. Two members shall be appointed for one-year terms, three members shall be appointed for two-year terms, three members shall be appointed for three-year terms and all subsequent appointments shall be made for three-year terms.

C. The New Mexico health policy commission shall meet at the call of the chairman and shall meet not less than quarterly. The chairman shall be elected from among the members of the commission.

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Members of the New Mexico health policy commission shall not be paid but shall receive per diem and mileage expenses as provided in the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978].

D. The New Mexico health policy commission shall establish task forces as needed to make recommendations to the commission on various health issues. Task force members may include individuals who have expertise or a pecuniary or fiduciary interest in the health services industry. Voting members of a task force may receive mileage expenses if they:

1. are members who represent consumer interests;
2. are individuals who were not appointed to represent views of the organization or agency for which they work; or
3. represent an organization that has a policy of not reimbursing travel expenses of employees or representatives for travel to meetings.

E. The New Mexico health policy commission shall:

1. develop a plan for and monitor the implementation of the state's health policy;
 2. obtain and evaluate information from a broad spectrum of New Mexico's society to develop and monitor the implementation of the state's health policy;
 3. obtain and evaluate information relating to factors that affect the availability and accessibility of health services and health care personnel in the public and private sectors;
 4. perform needs assessments on health personnel, health education and recruitment and retention and make recommendations regarding the training, recruitment, placement and retention of health professionals in underserved areas of the state;
 5. prepare and publish an annual report describing the progress in addressing the state's health policy and planning issues. The report shall include a workplan of goals and objectives for addressing the state's health policy and planning issues in the upcoming year;
 6. distribute the annual report to the governor, appropriate state agencies and interim legislative committees and interested parties;
 7. establish a process to prioritize recommendations on program development, resource allocation and proposed legislation;
 8. provide information and analysis on health issues;
 9. serve as a catalyst and synthesizer of health policy in the public and private sectors; and
 10. respond to requests by the executive and legislative branches of government.
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Health Information System Act

24-14A-1. Short title.

Chapter 24, Article 14A NMSA 1978 may be cited as the "Health Information System Act".

History: Laws 1989, ch.29, § 1; 1994, ch. 59, § 2.

24-14A-2. Definitions.

As used in the Health Information System Act [this article]:

- A. "aggregate data" means data which is obtained by combining like data in a manner which precludes specific identification of a single client or provider;
- B. "commission" means the New Mexico health policy commission;
- C. "department" means the department of health;
- D. "health information" or "health data" means any data relating to health care; health status, including environmental, social and economic factors; the health system; or health costs and financing;
- E. "hospital" means any general or special hospital licensed by the department, whether publicly or privately owned;
- F. "long-term care facility" means any skilled nursing facility or nursing facility licensed by the department, whether publicly or privately owned;
- G. "data source" includes those categories of persons or entities that possess health information, including any public or private sector licensed health care practitioner, primary care clinic, ambulatory surgery center, ambulatory urgent care center, ambulatory dialysis unit, home health agency, long-term care facility, hospital, pharmacy, third party payer and any public entity that has health information; and
- H. "third party payer" means any public or private payer of health care services and includes health maintenance organizations and health insurers.

History: Laws 1989, ch. 29, § 2; 1994, ch. 59, § 3.

24-14A-3. Health information system; creation; duties of commission.

A. The "health information system" is created for the purpose of assisting the commission, legislature and other agencies and organizations in the state's efforts in collecting, analyzing and disseminating health information to assist:

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1. in the performance of health planning and policymaking functions, including identifying personnel, facility, education and other resource needs and allocating financial, personnel and other resources where appropriate;
2. consumers in making informed decisions regarding health care; and
3. in administering, monitoring and evaluating a statewide health plan.

B. In carrying out its powers and duties pursuant to the Health Information System Act [this article], the commission shall not duplicate databases that exist in the public sector or databases in the private sector to which it has electronic access. Every governmental entity shall provide the commission with access to its health-related data as needed by the commission. The commission shall collect data from data sources in the most cost-effective and efficient manner.

C. The commission shall establish, operate and maintain the health information system.

D. In establishing, operating and maintaining the system, the commission shall:

(1) obtain information on the following health factors:

(a) mortality and natality, including accidental causes of death;

(b) morbidity;

(c) health behavior;

(d) disability;

(e) health system costs, availability, utilization and revenues;

(f) environmental factors;

(g) health personnel;

(h) demographic factors;

(i) social, cultural and economic conditions affecting health;

(j) family status; and

(k) medical and practice outcomes as measured by nationally accepted standards and quality of care;

(2) give the highest priority in data gathering to information needed to implement and monitor progress toward achievement of the state health policy, including determination where additional health resources such as personnel, programs and facilities are most needed, what those additional resources should be and how existing resources should be allocated.

(3) standardize collection and specific methods of measurement across databases and use scientific sampling or complete enumeration for collecting and reporting health information;

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(4) take adequate measures to provide system security for all health data acquired under the Health Information System Act and protect individual patient and provider confidentiality. The right to privacy for the individual shall be a major consideration in the collection and analysis of health data and shall be protected in the reporting of results;

(5) adopt and promulgate regulations necessary to establish and administer the provisions of the Health Information System Act, including an appeals process for data sources and procedures to protect data source proprietary information from public disclosure;

(6) establish definitions, formats and other common information standards for core health data elements of the health information system in order to provide an integrated financial, statistical and clinical health information system, including a geographic information system, that allows data sharing and linking across databases maintained by data sources and federal, state and local public agencies;

(7) develop and maintain health and health-related data inventories and technical documentation on data holdings in the public and private sectors;

(8) collect, analyze and make available health data to support preventive health care practices and to facilitate the establishment of appropriate benchmark data to measure performance improvements over time;

(9) establish and maintain a systematic approach to the collection and storage of health data for longitudinal, demographic and policy impact studies;

(10) use expert system-based protocols to identify individual and population health risk profiles and to assist in the delivery of primary and preventive health care services;

(11) collect health data sufficient for consumers to be able to evaluate health care services, plans providers, and payers and to make informed decisions regarding quality, cost and outcome of care across the spectrum of health care services, providers and payers;

(12) collect comprehensive information on major capital expenditures for facilities, equipment by type and by data source and significant facility capacity reductions; provided that for the purposes of this paragraph and Section 24-14A-5 NMSA 1978, "major capital expenditure" means purchases of at least one million dollars (\$1,000,000) for construction or renovation of facilities and at least five hundred thousand dollars (\$500,000) for purchase or lease of equipment, and "significant facility capacity reductions" means those reductions in facility capacities as defined by the advisory committee established by the commission;

(13) serve as a health information clearinghouse, including facilitating private and public collaborative, coordinated data collection and sharing and access to appropriate data and information, maintaining patient and client confidentiality in accordance with state and federal requirements; and

(14) collect data in the most cost-efficient and effective method feasible and adopt regulations, after receiving recommendations from the advisory committee, that place a limit on the maximum amount of unreimbursed costs that a data source can incur in any year for the purposes of complying with the data requirements of the Health Information System Act.

History: Laws 1989, Ch. 29, § 3; 1994, ch. 59, § 4.

24-14A-3.1. Advisory Committee.

A. The commission shall establish an advisory committee to assist it in identifying data needs, reviewing data and collection and reporting procedures, reviewing costs and benefits of obtaining data and determining report formats.

B. The advisory committee shall consist of representatives of private and public data sources; consumers; state agencies that deliver or pay for health care; and professionals with expertise in areas such as epidemiology, health economics, health care financing and information systems. Members of the advisory committee shall be appointed by the commission.

C. The nonpublic voting members may receive per diem and mileage under the following conditions:

(1) they are members who represent consumer interest;

(2) they are individuals who were not appointed to represent the views of the organization or agency for which they work; or

(3) they represent an organization that has a policy of not reimbursing travel expenses of employees or representatives for travel to meetings.

D. The advisory committee shall develop recommendations on:

(1) the specific data elements and their data sources to ascertain information on:

(a) quality of health care services, including access, appropriateness and consumer satisfaction;

(b) medical and practical outcomes, based on national standards;

(c) health system economics and finances, such as: 1) how much money is being spent on health care in New Mexico; 2) what health care services are being purchased; 3) where health care services are being purchased, both geographically and among health care providers; 4) what health care services are being used at what rates; 5) variations in costs and billed charges for the same health care services geographically and among health care providers; 6) causes of health care inflation in New Mexico; 7) rates and causes of increase in health care spending for different health services; and 8) reasonable premiums for given packages of benefits; and

(d) the release of patient information by physicians to ensure protection of confidentiality and privacy for patients;

(2) an appropriate procedure for processing non-aggregate data for public information and a schedule for phasing in the public release of non-aggregate information so that no later than July 1, 1997 the public will have access to information on which to base health care purchasing decisions;

(3) criteria and procedures to assess the costs and benefits of collecting and submitting data and criteria to determine when data sources need not provide data or may furnish data in an alternative form, due to unreasonable cost or burden of reporting; and

(4) a common definition of "proprietary" for all data sources.

History: Laws 1994, ch. 59, § 13.

24-14A-3.2. Health information alliance.

A. The commission shall establish a health information alliance that will be broadly representative of public and private entities interested in gathering, sharing and evaluating health information and advising the commission on the design of the health information system. The health information alliance shall assist the commission in applying for grants to establish and maintain a comprehensive integrated health information system.

B. The health information alliance shall:

(1) develop a conceptual strategic plan for a coordinated and integrated statewide health information network;

(2) advise the commission on the technical development of the health information network;

(3) assist the commission with modeling for collecting, organizing, processing, analyzing and disseminating health information;

(4) serve as a neutral forum for the creative and collaborative exploration of solutions to health information needs;

(5) assist the commission in identifying and applying for potential funding sources for the development of the health information network and the health information alliance; and

(6) identify, prioritize and formulate recommendations for funding software and hardware technology and models to address short- and long-term health information needs of the state.

C. The health information alliance and the commission shall report to the appropriate interim legislative committee by August 1, 1994 and every six months thereafter on their progress in developing an integrated health information network.

History: Laws 1994, ch.59, § 14.

24-14A-4. Health information system; applicability.

A. All data sources shall participate in the health information system. Requests for health data under the Health Information System Act [this article] from a member of a data source category shall, where reasonable and equitable, be made to all members of that data source category.

B. Upon making any request for health data pursuant to the Health Information System Act, the commission shall provide reasonable deadlines for compliance and shall give notice that noncompliance may subject the person to a civil penalty pursuant to Section 24-14A-10 NMSA 1978.

C. To the extent possible, the health information system shall be established in a manner to facilitate the exchange of information with other databases, including those maintained by the Indian health service and various agencies of the federal government.

History: Laws 1989, ch.29, § 4. 1994, ch.59, § 5.

24-14A-4.1. Annual review of data needs.

At least once each year, the commission, with the recommendations of the advisory committee and health information alliance, shall review its data collection requirements to determine the relevancy of the data elements on which it collects data and review its regulations and procedures for collecting, analyzing and reporting data for efficiency, effectiveness and appropriateness. The review shall consider the cost incurred by data sources to collect and submit data.

History: Laws 1994, ch.59, § 11.

24-14A-4.2. Investigatory powers.

The commission has the right to verify the accuracy of data provided by any data source. The verification may include requiring the data sources to submit documentation sufficient to verify the accuracy of the data in question or to provide direct inspection during normal business hours of only the records and documents that pertain directly to the data in question; provided that no data source shall be required to expend more than twenty-five thousand dollars (\$25,000) each year to comply with the provisions of this section.

History: Laws 1994, ch.59, § 12.

24-14A-4.3. Agency cooperation.

All state agencies and political subdivisions shall cooperate with and assist the commission in carrying out the provisions of the Health Information System Act [this article], including sharing information and joining in any appropriate health information system.

History: Laws 1994, ch.59, § 15.

24-14A-5. Health information system; implementation; regulations.

In order to minimize the imposition of new reporting requirements on persons subject to the provisions of the Health Information System Act [this article], the regulations to the extent reasonably possible shall provide that:

A. data shall be collected in a uniform manner;

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B. when practicable, data collection shall be through the use of a standardized billing form as required by law;

C. other health data required to be submitted may include:

(1) data that would customarily be collected in the ordinary course of business for the data source;

(2) annual audited financial statements customarily prepared by a data source;

(3) information on major capital expenditures;

(4) data established by regulation to be collected to carry out the requirements of the Health Information System Act; and

(5) data required to be collected by other state or federal laws; and

D. annual surveys or collection of data may be used as an alternative to collection of health data from some health service providers to the extent it can be shown that the information collected will meet validity and quality standards.

History: Laws 1989, ch.29, § 5. 1994, ch.59, § 6.

24-14A-6. Health information system; access.

A. Access to data in the health information system shall be provided in accordance with regulations adopted by the commission pursuant to the Health Information System Act [this article].

B. A data provider may obtain data it has submitted to the system, as well as aggregate data, but it may not access data submitted by another provider which is limited only to that provider. In no event may a data provider obtain data regarding an individual patient except in instances where that data was originally submitted by the requesting provider. Prior to the release of any data, in any form, data sources shall be permitted the opportunity to verify the accuracy of the data pertaining to that data source. Any data identified in writing as inaccurate shall be corrected prior to the data's release. Time limits shall be set for the submission and review of data by data sources and penalties shall be established for failure to submit and review the data within the established time.

C. Any person may obtain any aggregate data.

History: Laws 1989, ch.29, § 6. 1994, ch.59, § 7.

24-14A-7. Health information system; reports.

A. A report in printed format that provides information of use to the general public shall be produced annually. The report shall be made available upon request. The commission may make the report available on tape or other electronic format.

B. The commission shall provide an annual report of its activities, including health care system statistics, to the legislature. The report shall be submitted by November 15 each year.

History: Laws 1989, ch.29, § 7. 1994, ch.59, § 8.

24-14A-8. Health information system; confidentiality.

A. Health information collected and disseminated pursuant to the Health Information System Act [this article] is strictly confidential and shall not be a matter of public record or accessible to the public except as provided in Sections 24-14A-6 and 24-14A-7 NMSA 1978. No data source shall be liable for damages to any person for having furnished the information.

B. The individual forms, computer tapes or other forms of data collected by and furnished for the health information system shall not be public records to inspection pursuant to Section 14-2-1 NMSA 1978. Compilations of aggregate data prepared for release or dissemination from the data collected, except for a report prepared for an individual data provider containing information concerning only its transactions, shall be public records.

History: Laws 1989, ch.29, § 8. 1994, ch.59, § 9.

24-14A-9. Health information system; fees.

Except for the annual reports required pursuant to the Health Information System Act [this article], the commission may collect a fee of up to one hundred dollars (\$100) per hour to offset partially the costs of producing public-use data aggregations or data for single use special studies. Entities contributing data to the system shall be charged reduced rates. Rates shall be established by regulation and shall be reviewed annually. Fees collected pursuant to this section are appropriated to the commission to carry out the provisions of the Health Information System Act.

History: Laws 1989, ch.29, § 9. 1994, ch.59, § 10.

24-14A-10. Health information system; violation; civil penalty.

A It is unlawful for any person subject to the data reporting requirements of the Health Information System Act [this article] and the regulations adopted pursuant to that act not to comply with any of those requirements.

B. A civil action may be brought in the name of the state alleging a violation of Subsection A of this section and a petition may be made to the district court for temporary or permanent injunctive relief. In any such action, if the court finds that a person has willfully violated Subsection A of this section, upon petition to the court there may be recovered on behalf of the state a civil penalty not to exceed one thousand dollars (\$1,000).

History: Laws 1989, ch.29, § 10.

List of Stakeholders

INTERNAL STAKEHOLDERS

Staff

Liz Stefanics
Kooch Jacobus
TC Shaffer
Elisha Leyba
Tom Kauley
Terry Reusser
Lisa Marie Gomez
Peggy Schummers
Carlos Beserra
Reina Guillen
Dan Garcia
Marietta Esquibel
Tyson Pollman
Pat Mente
Mary Baca

Commissioners

Miles Nelson, MD
Moises Morales
Alicia Roman
Frank Hess, MD
Seferino Montano
Dawn Brooks, MSN, MBA
Karen Kotch, PA
Eric Kraska, MD
Kim Maxwell

EXTERNAL STAKEHOLDERS

Sharon Jones – Molina
Dan Derksen, MD – UNM – Ctr for Comm. Partner.
Bill Weise, MD – UNM – Inst. For Public Health
Reese Fullerton – DOL – Workforce Dev.
Diana Rivera – CYFD
Pat Putman – Dis. Council
Sen. Steve Komadina, MD – HHS Com
Sen. Sue Wilson Beffort – HHS Com.
Debbie Armstrong- Aging/LTC
Steve Durkovich – Trial Lawyers
Michelle Welby – Governor's Office
Karen Wells –LCS
Jack Abernathy – AARP
Lisa Cacari-Stone – Health Policy Consultant
Marlena Taylor - DFA
Jeff Dye – NMHHA
David Roddy - NMPCA